TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name
TRAVELERS INDEMNITY COMPANY OF CONNECTICUT

MFDR Tracking Number
M4-17-0400-02

Carrier's Austin Representative
Box Number 05

MFDR Date Received
October 17, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Based on CPT Code 29807, allowed amount of $4369.67 multiplied at 200%, CPT Code 94664, allowed amount of $131.43 multiplied at 200%, CPT Code 94770, allowed amount of $193.76 , multiplied at 200%, CPT Code 51798, allowed amount of $80.18, multiplied at 200%, and CPT Code 93005, allowed amount of $49.19, multiplied at 200% reimbursement should be $9,648.46. Payment received was only $8749.90 . . . there is a pending payment in the amount of $892.56."

Amount in Dispute: $898.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the documentation and determined the Provider is entitled to supplemental reimbursement for the disputed services. . . . With the supplemental reimbursement being issued, the Carrier contends the Provider is not entitled to additional reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 29, 2016 to May 2, 2016	Outpatient Hospital Services	$898.56	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.

4. The insurance carrier reduced payment for the disputed services during the bill review process and notified the health care provider of the below claim adjustment reason codes before the request for medical fee dispute resolution (MFDR) was filed with the division.

   The respondent subsequently made additional payments to the requestor after the filing of the medical fee dispute, and submitted additional explanations of benefits (EOBs) as part of the response. These subsequent explanations were not presented to the requestor prior to the filing of the MFDR request.

   Division Rule §133.307(d)(2)(F) requires that the response address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party.

   While any new payments will be duly considered and credited, the division finds that any new claim adjustment codes, denial reasons or defenses contained in the EOB's presented to the requestor *after* the filing of the MFDR request have been waived by the respondent. Any new denial reasons or defenses shall not be considered in this review, and are not listed among the claim adjustment codes below.
5. The medical fee dispute resolution request was filed on October 17, 2016. Review of the submitted information finds that the claim adjustment reason codes that were presented to the requestor prior to the filing of the MFDR request were:
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE
   - NDOC – THE DOCUMENTATION THAT WAS RECEIVED DOES NOT PROVIDE ENOUGH DETAILED INFORMATION TO DETERMINE THE APPROPRIATENESS OF THE BILLED SERVICE PROCEDURE
   - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 975 – CHARGE IS INCLUDED IN THE BASIC SURGICAL ALLOWANCE.
   - 8 – THE SUPPLY CHARGE WAS DISALLOWED AS IT WAS NOT ADEQUATELY IDENTIFIED. PLEASE RESUBMIT WITH INVOICE.
   - 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
   - 954 – THE ALLOWANCE FOR NORMALLY PACKAGED REVENUE AND/OR SERVICE CODES HAVE BEEN PAID IN ACCORDANCE WITH THE DISPERSED OUTPATIENT ALLOWANCE.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

   Per Rule §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure codes billed and supporting documentation. A payment rate is established for each APC. Hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items (including services billed without procedure codes) is packaged into the payment for each APC. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available from the Centers for Medicare and Medicaid Services (CMS).

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 93005, service date April 29, 2016, has status indicator Q1 denoting a conditionally packaged code. As no other status S, T, V or X codes were performed on the same date, this item is eligible for separate payment. This is classified under APC 5733, which, per OPPS Addendum A, has a payment rate of $55.94. This amount multiplied by 60% yields an unadjusted labor-related amount of $33.56. This amount multiplied by the facility's annual wage index of 0.7989 yields an adjusted labor-related amount of $26.81. The non-labor related portion is 40% of the APC rate, or $22.38. The sum of the labor and non-labor related amounts is $49.19. This line item is not eligible for outlier payment as the adjusted cost does not exceed the annual fixed-dollar threshold of $3,250. The Medicare facility specific reimbursement is $49.19. This amount multiplied by 200% yields a MAR of $98.38.
   - Procedure codes 36415, 80053, 86703, 85027 and 81001, service date April 29, 2016, have status indicators of Q4, denoting packaged laboratory services. Reimbursement for these items is included in the payment for procedure code 93005 billed on the same claim.
   - Procedure code 86592, service date April 29, 2016, has status indicator A, denoting services paid under a payment system other than OPPS. Per Rule §134.403(h), when Medicare pays using systems other than OPPS, division rules require those services be paid using the appropriate division fee guideline applicable to those services on the date provided. The facility technical component for pathology and lab services is paid using the DWC Professional Fee Guideline, Rule §134.203(e)(1). The Medicare Clinical Fee Schedule rate for this code is $5.82. 125% of this amount is $7.28.
   - Procedure codes A6222, A4565, 94760, J2765, J3010, J2250, J2405, J2795, J2710, J0690, J1030 and C1713 have status indicators of N, denoting packaged codes with no separate payment—these items are integral to the total service package; reimbursement is included in the payment for the primary procedure.
   - Procedure codes 36415, 80053, 86703, 85027 and 81001, date of service April 29, 2016, have status indicators of Q4 denoting packaged laboratory services. Per Medicare payment policy, reimbursement for these services is included in the payment for procedure code 93005 billed on the same claim.
   - Procedure code 29807, service date May 2, 2016, has status indicator J1 denoting packaged services paid at a comprehensive APC rate. All covered services on the May 2, 2016 bill are packaged with the primary "J1" procedure. This code is classified under APC 5123, which, per OPPS Addendum A, has a payment rate of $4,969.26. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,981.56. This amount multiplied by the facility's annual wage index of 0.7989 yields an adjusted labor-related amount of $2,381.97. The non-labor related portion is 40% of the APC rate or $1,987.70. The sum of the labor and non-labor related amounts is $4,369.67. This line item is not eligible for outlier payment as the adjusted cost does not exceed the annual fixed-dollar threshold of $3,250. The Medicare facility specific reimbursement is $4,369.67. This amount multiplied by 200% yields a MAR of $8,739.34.
   - Procedure codes 94664 and 51798 have status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X that are billed for the same date of service. This code may be separately payable only if no other such procedures are billed for the same date. Reimbursement for these services is included in the payment for procedure code 94770, a service with status indicator S billed for the same date.
   - Per Medicare policy, procedure code 94770 is packaged with procedure code 29807, a comprehensive status J1 code billed on the same claim. Reimbursement for this service is included in the payment for the primary procedure. Separate payment is not recommended.
   - Procedure code A9270 has status indicator E denoting excluded or non-covered codes not payable if submitted on an outpatient bill. Reimbursement is not recommended.

3. The total recommended reimbursement for the services in dispute is $8,845.00. This amount less the amount previously paid by the insurance carrier of $8,849.33 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the information submitted by the parties, in accordance with the provisions of Texas Labor Code §413.031, the division determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	February 3, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.